Dr Daniel Consulting Rooms

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services well-led?	Inadequate

Overall summary

This service is rated as Requires improvement overall. (Previous inspection February 2020 – Requires improvement)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced focused inspection at Dr Daniel Consulting Rooms to follow up on previous breaches of regulations. During this inspection we inspected safe, effective and well led.

CQC inspected the service in February 2020. We rated the service as requires improvement overall due to concerns with risk identified by building management not being monitored, a lack of continuous audit activity to demonstrate positive clinical improvements to patients and staff not receiving formal training. The service was given requirement notices.

We checked these areas as part of this focused inspection and found some improvements had been made whilst others remained unresolved. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

Dr Daniel Consulting Rooms, also known as Foresight Medical Centre, is an independent GP practice located in the London Borough of Westminster. The provider is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Not all staff had received mandatory training relevant to their role. The lead GP did not have the appropriate level of safeguarding training for vulnerable adults and children.
- The provider did not have a defined set of mandatory training that staff needed to complete to carry out their role effectively.
- The governance systems in place were not always effective in overseeing risk.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- Staff said that they felt happy to raise concerns or issues to the provider.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance

Overall summary

with the fundamental standards of care.

- Ensure persons employed in the provision of the regulated activity receive the

Appropriate support, training and appraisal necessary to enable them to carry out the duties.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Improve service policies to ensure they are service specific.
- Continue to monitor and review quality improvement for patients.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a specialist adviser.

Background to Dr Daniel Consulting Rooms

Dr Daniel Consulting Rooms, also known as Foresight Medical Centre, is located at 99 Harley Street, London W1G 6AQ. The building entrance lobby is accessed via two steps from the pavement. Wheelchair access is via a ramp (patients are advised of this and a member of staff is available to assist patients). The service is easily accessible by public transport and is a short walk from Regents Park Station. The provider did not offer translating services or chaperone and patients were informed of this at registration. There are approximately 6,000 registered patients. The service sees approximately 20 patients a week. The practice team consists of a female GP principal (full-time), who is also the practice manager and two part time secretaries. The practice is open from 9am to 5pm Monday to Friday.

The practice offers consultations and treatment for adults 18 years and older. Services provided include management of long-term conditions; gynaecological assessment; ECG (Electrocardiogram); blood and other laboratory tests; and vaccinations. Patients can be referred to other services for diagnostic imaging and specialist care. The provider is registered with the Care Quality Commission (CQC) for the regulated activities of Diagnostic & Screening Procedures, and Treatment of Disease Disorder or Injury.

The service website address is: www.foresightmedical.co.uk We visited Dr Daniel Consulting Rooms on 11 October 2021. The team was led by a CQC inspector, accompanied by a GP specialist advisor. Before the inspection, we reviewed notifications received about the service, and a standard information questionnaire completed by the service. During the inspection, we interviewed staff, made observations and reviewed documents.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

We carried out this inspection on 11 October 2021. The inspection was led by a CQC inspector who was accompanied by a GP specialist advisor. Before visiting, we looked at a range of information that we hold about the service. We reviewed the last inspection report from February 2020 and information submitted by the service in response to our provider information request. During our visit we interviewed staff (GP principal who was also the practice manager and a secretary), observed practice and reviewed documents.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

- Is it safe?
- Is it effective?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

Care and treatment were not always provided safely as not all staff were trained up to the appropriate levels of safeguarding adults and children for their roles and infection control. The building management carried out safety assessments, however the provider could not demonstrate they effectively monitored this. There was no infection control audit or any cleaning schedules.

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- In our inspection in January 2019, February 2020 and this inspection we continued to find that clinical staff and non-clinical staff were not appropriately trained for safeguarding. At this inspection, we found the practice did not have a safeguarding policy, the GP was not trained to the appropriate level of safeguarding adults and children for their role, as set out in Intercollegiate Guidelines for clinical staff. We also noted one non-clinical staff member had not completed safeguarding training to the appropriate level for their role. (It is a requirement set out in the Intercollegiate Guidelines for non-clinical staff to be trained in safeguarding children to level two).The lead GP showed us evidence that she was booked to attend safeguarding and mental capacity training in October 2021 prior to the inspection, however she did not attend training and this remains outstanding. We noted that the GP took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We found that there was an ineffective system in place to manage infection prevention and control (IPC) including staff not receiving IPC training and audits not being carried out to monitor and manage IPC. The lead GP and a non-clinical staff member had not completed any infection control training, this was also raised at the last inspection.
- There was no infection control audit, this was raised at the last inspection.
- There was no cleaning schedule, however the service looked clean. The lead GP informed us she was responsible for cleaning.
- The infection prevention and control (IPC) policy was not unique to the service, it made references to having an infection control team consisting of specialist nursing and medical staff, it also referred to colour coding of hospital cleaning materials which were not in place at the service.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- There were comprehensive risk assessments in relation to safety issues such as fire, water and general health and safety. These had been arranged by the building's management. However, the practice did not monitor and review this activity and therefore could not be assured that outstanding actions had been implemented. This was raised at the last inspection.
- There was no risk assessments done on the room used to see patients.
- The provider carried out Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We saw a recruitment policy and an employee induction check list.
- We saw a legionella risk assessment had been carried out by the building management via an external company February 2020. The current risk of legionella in the water system was deemed to be medium. We could not see that that the provider was assuring themselves with the building management that recommendations were being followed.
- There were systems for safely managing healthcare waste.

Risks to patients

Requires Improvement

Are services safe?

There were some systems to assess, monitor and manage risks to patient safety.

- We found one staff member had completed basic life support training, however the lead GP had not undertaking any basic life support training since December 2019, another non-clinical staff member had not undertaken any training.
- There were arrangements for planning and monitoring the number and mix of staff needed. When there were changes to services or staff the service assessed and monitored the impact on safety. The service had a business continuity plan in place.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision.
- A fire drill was last completed in August 2019. We were told the next one was due August 2020. The service showed us an email dated October 2021 from health & safety managers explaining they were working with property managers for a new fire drill to take place. This had been put on hold due to the pandemic.
- No equipment calibration had been done since February 2020. There was no risk assessment for not undertaking this**.**
- No portable appliance testing had been completed in 2020 or 2021 due to COVID. (There was no risk assessment for not having it done). The cold chain policy said that portable appliance testing (PAT) testing was carried out annually.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. However, when we asked to see a policy to ensure information is shared with others, we were told the provider did not have one.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- We saw the service had a comprehensive information security policy.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. However there was only one thermometer on the fridge working, the GP explained that the data logger had stopped working recently and she had ordered a new one. She also said that the fridge had been switched off/not used since April 2020 till September 2021.
- The service kept prescription stationery securely and monitored its use.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing, for example the antibiotic prescribing audit.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

Requires Improvement

Are services safe?

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.
- There were effective protocols for verifying the identity of patients.

Track record on safety and incidents

- **The service had a good safety record. However, improvement was still required to ensure effective monitoring.**
- There were comprehensive risk assessments in relation to safety issues such as fire, water and general health and safety. These had been arranged by the building's management. However, the practice did not monitor and review this activity and therefore could not be assured that outstanding actions had been implemented.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and this was managed by the GP. Staff understood their duty to raise concerns and report incidents and near misses. However, the practice did not have a formal policy to describe this system.
- There were systems in place for reviewing and investigating when things went wrong. We were told there had been no significant events in the last 12 months.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

As identified at the last inspection, the provider had not determined what training it required staff to undertake in order to safely meet the needs of their patients. Staff were not trained up to the appropriate levels of safeguarding adults and children for their roles including the lead GP. The lead GP and one non-clinical staff member had not undertaken infection control, mental capacity, fire, information governance, or basic life support training. The provider undertook limited quality improvement activity; however this had improved since the last inspection.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation,

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- The GP had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions. Arrangements were in place to deal with repeat patients.
- The GP assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. For example, the provider had undertaken limited quality improvement activity however we saw one audit in relation to antibiotic usage, as a result of the audit the provider changed the use of antibiotics to reflect guideline/recommendations of reduced broad spectrum use from six percent of prescriptions being antibiotics compared to eight point five percent the previous year, we did not see audits prior to this one or after this one.

Effective staffing

The provider did not understand the learning needs of staff.

- At our previous inspection on 19 February 2020 we found the provider had not determined what training staff needed to meet the needs of their patients. At this inspection, we found that the provider had not made enough improvement in this area. There was no ongoing schedule of training for staff to undertake and update, and as a result there were continued gaps in training records. For example, the GP had not undertaken formal training in the mental capacity act, infection control, fire safety, health and safety, equality and diversity, information governance, or appropriate safeguarding training. The lead GP showed us evidence that she was booked to attend safeguard and mental capacity training in October, however she did not attend training, this remains outstanding.[1]
- One non-clinical staff member had completed all relevant training and another non-clinical staff member had not received any formal training in safeguarding children or vulnerable adults, fire safety, health and safety, infection control, equality and diversity, or information governance.

Requires Improvement

Are services effective?

- Although the provider had an induction programme for all newly appointed staff, this did not include the completion of relevant training.
- The GP was registered with the General Medical Council (GMC) and was up to date with revalidation.
- The GP, whose role included immunisation and reviews of patients with long term conditions, had received specific training and could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centered care. Staff referred to, and communicated effectively with, other services when appropriate. For example, when making referrals to specialist consultants.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation with their registered GP during registration.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were arrangements for following up on people who had been referred to other services. However, when we asked to see a policy to ensure information is shared with others, we were told the provider did not have one.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

At our previous inspection, February 2020 we asked the provider to send us a report of action they were going to take to meet the legal requirements of the Health and Social Act 2008, its associated regulations or any other relevant legislation. The provider failed to submit an action plan to this effect. At this inspection we found there were continued areas of concerns which had not been addressed since the last inspection, for example insufficient staff training, ineffective arrangements for infection prevention and control, failure to follow up on risk assessment actions and recommendations as well as an overall lack of clarity around processes for managing risks, issues and governance arrangements.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy although there were no supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Staff had not received regular annual appraisals in the last year.
- There was a strong emphasis on the well-being of all staff.
- One staff member had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability, however these were not effective and did not support good governance and management.

Inadequate

Are services well-led?

- Following our last inspection in February 2020 we asked the provider to send us a report of the action they were going to take to meeting the legal requirements of the Health and Social Care Act 2008, its associated regulations, or any other relevant legislation. The provider failed to submit an action plan to this effect.
- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective.
- At this inspection we found the provider had made some improvements. For example, the provider had carried out an audit of antibiotic use, looking at changing the use of antibiotics to reflect guideline recommendations of reduced broad-spectrum use.
- Some of the services policies had been reviewed and updated. However, some polices did not exist, for example there was no safeguarding policy, or significant events policy. Some polices were not service specific, for example the infection control audit. Some polices were not adhered to, for example the service failed to follow their recruitment policies such as undertaking annual appraisals. The infection control policy was not adhered to as it mentioned training was mandatory for all staff on a regular basis, however the lead GP and one non-clinical staff member had not completed any training.
- Concerns identified at the last inspection had not been addressed at this inspection, for example staff training, and following up actions from risk assessments.
- Staff were clear on their roles and accountabilities.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There was a lack of clarity around processes for managing risks, issues and performance.

- At the last inspection we identified concerns in relation to the processes to identify, understand, monitor and address current and future risks including risks to patient safety. These concerns had not improved at this inspection for example, some staff lacked training in basic life support, infection control, safeguarding and information governance.
- Although risk assessments relating to the premises were arranged and managed by the building's management, the practice did not monitor and review this activity and therefore could not be assured that outstanding actions had been implemented. This was raised at the last inspection. This was in relation to issues such as fire, water and general health and safety. All risk assessments highlighted areas for improvements and actions to be completed.
- The provider last undertook a fire drill in August 2019. We saw an email from the building's health & safety managers- explaining they are working with property managers for a new fire drill to take place, as it was put on hold due to the pandemic.
- No equipment calibration had been done since February 2020. There was no risk assessment for not having done it.
- No Portable Appliance Testing (PAT) had been done since 2019, we were told this was due to COVID, there was no risk assessment for not having done it. The cold chain policy said that PAT testing was carried out annually.
- The was only one thermometer in the fridge working, the GP explained that the data logger had stopped working recently and she had ordered a new one, we saw no evidence of this. She also explained that the fridge had been switched off/not used since April 2020 till September 2021.
- Although there were risk assessments for the whole building there was nothing for the actual location rooms used.
- There were no cleaning schedules, and the service had not undertaken an infection control audit.

Inadequate

Are services well-led?

- The service had processes to manage current and future performance. For example, the GP received feedback on their referrals from specialists and performance reports from the laboratory. The GP had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. For example, staff showed us a patient feedback form, they also informed us the lead GP had daily meetings and staff members would leave hand over notes for each other. (We saw evidence of feedback opportunities for staff and how the findings were fed back to staff).
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- There was a lack of focus on continuous learning and improvement, most staff members had not completed training.
- The service made use of internal and external reviews of incidents and complaints.
- The lead GP informed us she followed NICE guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance A Warning Notice was issued in respect of this Regulation, as the provider had failed to ensure that systems or processes were established and operated effectively. In particular: • The provider failed to review, and monitor risk identified by the building management. • The provider failed to have a safeguarding policy, significant events policy and a policy to ensure information shared with others. • The provider failed to follow their recruitment policies such as undertaking annual appraisals. • The infection control policy was not unique to the provider. • The infection control policy was not adhered to as it mentioned training was mandatory for all staff on a regular basis, however the lead GP and one non-clinical staff member had not completed any training. • The provider failed to undertake an infection control audit. • There were no cleaning schedules. • The provider had failed to undertake risk assessments for not checking equipment. • There was only one thermometer on the fridge working.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing A Warning Notice was issued in respect of this Regulation, as the provider had failed to ensure staff employed undertook appropriate training as was necessary to carry out their duties. In particular:

This section is primarily information for the provider

Enforcement actions

- Non-clinical staff had not received formal training that included: basic life support safeguarding children, safeguarding vulnerable adults, fire safety, health and safety, infection control, equality and diversity, or information governance.
- The GP had not undertaken formal training in basic life support, safeguarding children, safeguarding vulnerable adults, mental capacity act, infection control, fire safety, health and safety, equality and diversity or information governance.
- Staff had not had appraisals.
- There was no process for checking non-clinical staff immunity.